# Exhibit 4

**IN RE: NEW ENGLAND COMPOUNDING PHARMACY INC.**

**CONFIDENTIAL PERSONAL INJURY OR WRONGFUL DEATH CLAIM FACT SHEET**

**IMPORTANT - DO NOT FILE THIS DOCUMENT WITH THE COURT - SEE SPECIAL INSTRUCTIONS TITLED "NOTICE OF DEADLINES FOR FILING CLAIMS AND CLAIM PROCEDURES."**

Please provide the following information **TO THE BEST OF YOUR ABILITY** for each individual making a claim about exposure to New England Compounding Pharmacy, Inc. d/b/a New England Compounding Center ("NECC") products. More information, including a list of NECC products, is available at http://www.cdc.gov/hai/outbreaks/meningitis-facilities-map.html and http://www.donlinrecano.com/necp. SEE SPECIAL INSTRUCTIONS ENTITLED "NOTICE OF DEADLINES FOR FILING CLAIMS AND CLAIMS PROCEDURES." You will need to submit this Fact Sheet by _____ 2013 at 4:00 p.m. (prevailing Eastern Time) or within 60 days of filing your Complaint if you have not already filed it.

- "You" used in this Fact Sheet means the person who was exposed to NECC products.
- "Product" means any medication or solution compounded by NECC.
- In filling out any section or sub-section of this Fact Sheet, please submit additional sheets as necessary to provide complete information.
- If, at a later date, you learn that any of your responses are incomplete or incorrect, please submit that information as soon as you become aware of it. In addition, supplemental information and documentation will likely be requested after you submit this initial Fact Sheet.

In completing this Fact Sheet, you are considered to have done so under oath. You must provide information that is true and correct to the best of your knowledge, information, and belief. If information is not known, remembered, or available, please indicate that in the appropriate location.

After reviewing your Fact Sheet, additional information and documentation will likely be requested from you. Please contact the your attorney immediately if you need to correct any of your answers or can provide more complete information. You may and should consult with your attorney regarding completing this Fact Sheet. IF YOU ARE NOT REPRESENTED BY COUNSEL OR OTHERWISE ARE UNABLE TO FURNISH ANY OF THE INFORMATION REQUESTED, PLEASE PROVIDE AS MUCH OF THE INFORMATION AS YOU CAN.

******Please Do Not Contact the Court With Any Questions or for Additional Information******

**********

## I. CASE INFORMATION

1. Name of person on whose behalf a claim is being made (first, middle name or initial, last), including maiden or other names used:

_____

a. Were you (or the person identified above) administered the steroid methylprednisolone acetate?

☐ Yes ☐ No ☐ Do Not Know

b. Were you (or the person identified above) administered another NECC Product?

☐ Yes ☐ No ☐ Do Not Know

If yes, please identify: _____

2. Name of person signing this form, if different from above:

_____

a. Relationship of signer to party on behalf of whom claim is being made (such as spouse, parent, family member, adult child, guardian):

b. If the person completing this Fact Sheet is completing this questionnaire in a representative capacity (*e.g.*, on behalf of the estate of a deceased person or a minor) ("Representative"), please complete the following:

1. Representative's Social Security Number (***Last 4 digits ONLY***):

XXX-XX-_____.

2. Maiden or other names used or by which Representative has been known:

_____

3. Address:

_____

_____

4. State which individual or estate the Representative is representing, and in what capacity the Representative is representing the individual or estate (guardian, administrator, executor, etc.)?

_____

5. If appointed as a Representative by a court, please identify the court:

_____

Date of Appointment: _____

6. What is the familial or other relationship between the Representative and the deceased or represented person, or person claimed to be injured? _____

_____

7. If the Representative is representing a decedent's estate, please state the date of death, the address where the decedent died, and the cause of death and attach a copy of the death certificate if available: _____

_____

_____

_____

3. Please check the injuries you sustained as a result of exposure to the NECC Product(s):

a. ☐ Death

b. ☐ Fungal Meningitis

c. ☐ Arachnoiditis (persistent nerve pain)

d. ☐ Phlegmon (persistent nerve pain at base of spine)

e. ☐ Osteomyelitis (infection in bone, including vertebral or diskitis)

f. ☐ Sacroiliitis (pain at base of spine)

g. ☐ Peripheral Joint Pain (at site of injection)

h. ☐ Septic Arthritis

i. ☐ Epidural Abscess

j. ☐ Stroke or stroke like symptoms (Cerebral Vascular Accident)

k. ☐ Lumbar Puncture (Spinal Tap), Subsequent Treatment

l. ☐ Lumbar Puncture (Spinal Tap), No Subsequent Treatment

m. ☐ Infection of any kind, describe if known:

n. ☐ Injection only, no symptoms or treatment

o. ☐ Other (describe): _____

(Attach additional sheets if necessary to describe.)

4. Was any lawsuit or civil action started based on your exposure to an NECC Product, including any claiming wrongful death or claiming on behalf of an estate or survivors?

☐ Yes ☐ No

If Yes, please state:

a. Case Caption:

_____

b. Court and Docket Number:

_____

c. Name, address, telephone number, fax number and e-mail address of attorney representing you, if you know:

Attorney Name: _____

Firm Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Email Address: _____

*****The Rest of This Form Requests Information About The Person Exposed to the Product*****

## II. PERSONAL INFORMATION

5. Maiden name and other names used or by which you have been known:

_____

6. Social Security Number (***Last 4 digits ONLY***): XXX-XX-_____

7. Date and Place of Birth:

_____

8. Sex: ☐ Male ☐ Female

9. Driver's License Number and State Issuing License: _____

10. Current address and date(s) when you lived at this address:

_____

_____

11. Identify each address at which you have resided during the last TEN (10) years, and list when you started and stopped living at each one:

| Address | Dates of Residence |
|---|---|
| | |
| | |
| | |
| | |
| | |

12. Identify the highest level of education (high school, college, university or other educational institution) you have attended (even if not completed), the dates of attendance, courses of study pursued, and diplomas or degrees awarded:

| Institution | Dates Attended | Course of Study | Diplomas or Degrees |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

13. Are you married? ☐ Yes ☐ No

14. As an adult, have you ever been convicted or plead guilty to a felony or a crime of fraud, dishonesty, or moral turpitude? ☐ Yes ☐ No If you answered "Yes," describe where, when and the felony and/or crime. _____

_____

_____

_____

## III. EMPLOYMENT INFORMATION

15. Are you making a claim for past lost wages or future lost earning capacity or other economic loss, other than for medical bills? ☐ Yes ☐ No

16. If you answered "Yes" to Question 15 or you are not sure, then answer the next three questions.

a. Current employer (if not currently employed, last employer):

| Name | Address | Dates of Employment | Occupation/Job Duties |
|---|---|---|---|
| | | | |

b. List the following for each employer you have had in the last TEN (10) years:

| Name | Address | Dates of Employment | Occupation/Job Duties |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

17. Are you making a wage loss claim for either your present or previous employment? ☐ Yes ☐ No

If you answered "Yes," please provide:

a. Your annual income at the time of the injury/injuries alleged above to have been caused by your exposure to the NECC Product: _____

b. Your annual income presently: _____

c. The total amount of income you claim to have lost as a result of injuries you associate with your exposure to the NECC Product: _____

d. A narrative description of how you calculated the total amount in Question 17c above:
_____
_____
_____

18. Have you ever served in the military, including the military reserve or national guard?

☐ Yes ☐ No

If you answered "Yes," answer the following question: Were you ever rejected or discharged from military service for any reason? ☐ Yes ☐ No If you answered "yes," to the best of your knowledge please state the reason for your rejection or discharge:
_____
_____

## IV. INSURANCE/DISABILITY

19. Have you ever filed a social security disability (SSI or SSD) claim? ☐ Yes ☐ No

If you answered "Yes," to the best of your knowledge please state:

Year claim was filed: _____

_____

Nature of disability: _____

Approximate period of disability: _____

20. Have you filed a disability claim with any private insurance company or local/state/federal agency? ☐ Yes ☐ No

If Yes, when? _____

21. Have you ever filed a worker's compensation claim? ☐ Yes ☐ No If you answered "Yes," to the best of your knowledge please state:

Year claim was filed: _____

_____

Nature of claim: _____

Approximate period of disability: _____

22. In the last 10 years, have you been out of work for more than 30 days for reason related to your health (other than pregnancy)? ☐ Yes ☐ No If you answered "Yes," set forth when and the reason. _____

_____

_____

_____

23. Other than the present suit, have you ever filed a lawsuit or made a claim relating to any bodily injury? ☐ Yes ☐ No If you answered "Yes," state to the best of your knowledge the court in which such action was filed, case name and/or names of adverse parties, and a brief description of the claims asserted. _____

_____

_____

_____

_____

24. Did you have medical insurance for treatment rendered in this case?

☐ Yes ☐ No

a. If Yes, please provide the following information for each insurance company. If more than one, please provide information for all:

Name of Health Insurance and/or coordinator of benefits/plan administrator:

_____

Policy Number: _____

Name of Subscriber: _____

b. If you have Medicare or Medicaid coverage, please state your ID number:

_____

c. Has any insurance company asserted a lien on your recovery?

☐ Yes ☐ No

lf Yes, please provide the name and address of the lienholder: _____

_____

## V. FAMILY INFORMATION

25. List for each marriage the name of your spouse; spouse's date of birth (for your current spouse only); spouse's current employer and occupation; date of marriage; date the marriage ended, if applicable; and how the marriage ended (*e.g.*, divorce, annulment, death): _____

_____

_____

_____

26. Has your spouse or any other family member filed a loss of consortium claim in this action?

☐ Yes ☐ No If you answered "Yes," state the name of your spouse or family member(s) filing the loss of consortium claim and their relationship to you. _____

_____

_____

27. To the best of your knowledge, has any child, parent, sibling or grandparent of yours been diagnosed with any form of immune disorder (*e.g.*, HIV, AIDS, ) or auto-immune disorder (Crohn's disease, lupus, etc.)? ☐ Yes ☐ No If you answered "Yes," identify each such person below and provide the information requested.

Name: _____

Current Age (or Age at Death): _____

Type of Disease: _____

If Applicable, Cause of Death: _____

28. To the best of your knowledge, did any child, parent, sibling, or grandparent of yours suffer from any of the following: arthritis/joint pain, chronic pain, diabetes, heart attack, cardiac disease, high cholesterol, high blood pressure, blood clots, coronary artery disease, congestive heart failure, deep vein thrombosis, vascular disease, transient ischemic attack, or stroke?

☐ Yes ☐ No ☐ Don't Know If you answered "Yes," identify each such person below and provide the information requested.

Name: _____

Current Age (or Age at Death): _____

Type of Problem: _____

If Applicable, Cause of Death: _____

29. If applicable, for each of your children, list his/her name, age and address:

_____
_____
_____
_____
_____

If the person who was allegedly injured as a result of being exposed to the NECC Product is deceased, list any and all heirs of the decedent:

_____
_____
_____

30. Are there persons (other than those already identified in this Fact Sheet) you believe are witnesses to your claimed injuries or the damages? If so, please provide their name(s) and address(es):

_____
_____
_____
_____

## VI. MEDICAL INFORMATION

31. Date(s) you were administered or used an NECC Product:

_____

32. Hospital/clinic/physician's office where you were administered the NECC Product:

Name:_____

Full Address:

_____
_____
_____

33. Physician(s) who administered the NECC Product:

Name: _____

Full Address:

_____

_____

_____

34. What medical condition(s) did you have for which you were treated with the NECC Product (for example, osteoarthritis, back injury, etc.)?

_____

35. Identify your treating physician for the condition(s) in the preceding question if that physician is different from the one who administered the NECC Product:

Name: _____

Full Address: _____

_____

_____

36. Have you received other steroid injections with products manufactured or compounded by entities other than NECC? ☐ Yes ☐ No If you answered "Yes," state the product(s) and, if known, the entities which manufactured or compounded the products:_____

_____

37. If you claim to have experienced symptoms or injuries from the administration of the NECC Product, when did you first experience symptoms and what symptoms did you have?_____

_____

38. Have you been tested for meningitis or fungal infection? ☐ Yes ☐ No

a. If Yes, provide:

1. Where? Name and full address of facility:_____

_____

_____

2. When? Date(s) of tests:

_____

3. Have you had a lumbar puncture/spinal tap since your exposure to an NECC Product? ☐ Yes ☐ No

39. Who, if anyone, diagnosed your condition(s) that you claim is associated with your exposure to an NECC Product? If you identify anyone in response to this question, please identify that person by name and full address: _____

_____

_____

40. Are any of the conditions you describe in response to Question 3 still affecting you? ☐ Yes ☐ No

If Yes, please describe: _____

41. Are you claiming that you have suffered or may develop bodily injury/injuries as a result of exposure to an NECC Product? ☐ Yes ☐ No If you answered "Yes," then please answer the following questions:

a. Who, if anyone, diagnosed your condition(s) that you claim is associated with your exposure to an NECC Product in Question 3? _____

b. Has any health care provider told you, your agents, representatives or anyone acting on your behalf, orally or in writing, that any of the injuries, damages or conditions that you identified in response to Question 3 are due to exposure to an NECC Product? ☐ Yes ☐ No If you answered "Yes," then state and describe:

1. What you (or your agents, representatives or anyone acting on your behalf) were told: _____

2. Who told you (or your agents, representatives or anyone acting on your behalf) and when: _____

3. Have you ever suffered this type of injury/injuries prior to the date set forth in answer to the prior question? ☐ Yes ☐ No If you answered "Yes," when and who diagnosed the condition(s) at that time? _____

42. Do you claim that your exposure to an NECC Product made a condition(s) or injury that you already had or had in the past worse? ☐ Yes ☐ No If you answered "Yes," set forth the injury or condition; state how you allege the NECC Product made the injury or condition worse; whether or not you had already recovered from that injury or condition before you were exposed to the NECC Product; and the date of recovery, if any. _____

43. Are you claiming mental and/or emotional damages as a consequence of exposure to the NECC Product?

☐ Yes ☐ No If you answered "Yes," for each provider (including, but not limited to a primary care physician, psychiatrist, psychologist, counselor, or therapist) from whom you have sought treatment for psychological, psychiatric, emotional, and/or marital problems during the last TEN (10) years, state:

a. Name and address of each person who treated you: _____

_____

_____

_____

b. To your understanding, the condition(s) for which you were treated: _____

_____

_____

_____

c. When you were treated: _____

_____

d. Medications prescribed or recommended by provider: _____

_____

## VII. COMMUNICATIONS WITH HEALTHCARE PROVIDERS

44. Do you remember any communication that you have had with a Healthcare Provider employee or representative related to the NECC Product?

☐ Yes ☐ No If you answered "Yes," please identify each employee or representative:

a. Who? _____

b. When? _____

c. To the best of your ability, please describe each communication with a Healthcare Provider employee(s) or representative(s) related to the NECC Product:

_____

_____

_____

_____

_____

_____

_____

_____

## VIII. MEDICAL BACKGROUND

45. What is your current height? _____

46. What is your current weight? _____

47. Smoking/Tobacco Use History: Check the answer and fill in the blanks applicable to your history of smoking and/or tobacco use.

___ Never smoked cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.

___ Past smoker of cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.
a. Date on which smoking/tobacco use ceased: _____
b. Amount smoked or used: on average _____ per day for _____ years.
___ Current smoker of cigarettes/cigars/pipe tobacco or user of chewing tobacco/snuff.
a. Amount smoked or used: on average _____ per day for _____ years.

48. Alcohol Use: Do you now drink or have you in the past TEN (10) years drunk alcohol (beer, wine, whiskey, etc.)? ☐ Yes ☐ No If you answered "Yes," fill in the appropriate blank with the number of drinks that represents your average alcohol consumption during the past TEN (10) years:

_____ drinks per day,
_____ drinks per week,
_____ drinks per month, ***or***

Other (describe): _____

49. Illicit Drugs: Have you used any illicit drugs of any kind (including injectable drugs) within one (1) year before, or any time after, you received an NECC Product? ☐ Yes ☐ No If you answered "Yes," identify each substance and state when you first and last used it. _____
_____
_____
_____

50. Have you been diagnosed with any form of immune disorder (including HIV/AIDS) or auto-immune disorder (including lupus, Inflammatory Bowel Syndrome, Crohn's disease, ulcerative colitis, mixed connective tissue disease)? ☐ Yes ☐ No If you answered "Yes," provide the following information:

| Condition | When | Treating Physician | Hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

51. To the best of your knowledge, during the past TEN (10) years, have you ever suffered from or been diagnosed by a doctor or other health care provider with:

| | | Yes | No | Don't Recall |
|---|---|---|---|---|
| a. | High cholesterol | ___ | ___ | ___ |
| b. | Hypertension/high blood pressure | ___ | ___ | ___ |
| c. | Obesity | ___ | ___ | ___ |
| d. | Diabetes | ___ | ___ | ___ |
| e. | Neuropathy | ___ | ___ | ___ |
| f. | Thyroid disorder | ___ | ___ | ___ |
| g. | Arthritis/joint pain | ___ | ___ | ___ |
| h. | Chronic pain | ___ | ___ | ___ |

| | | Yes | No | Don't Recall |
|---|---|---|---|---|
| i. | Autoimmune disease (including HIV, AIDS, or Crohn's disease) | ___ | ___ | ___ |
| j. | Congestive heart failure | ___ | ___ | ___ |
| k. | Myocardial infarction (MI), heart attack, or other heart disease | ___ | ___ | ___ |
| l. | Stroke or transient ischemic attacks (TIAs) | ___ | ___ | ___ |
| m. | Chronic obstructive pulmonary disease (COPD) or other respiratory disorder | ___ | ___ | ___ |
| n. | Liver disease or jaundice | ___ | ___ | ___ |
| o. | Metabolic syndrome | ___ | ___ | ___ |
| p. | Enlarged prostate | ___ | ___ | ___ |
| q. | Arteriosclerosis (hardening of the arteries) or other vascular disease | ___ | ___ | ___ |
| r. | Osteomyelitis | ___ | ___ | ___ |
| s. | Abscess | ___ | ___ | ___ |
| t. | Depression or emotional issues requiring medication | ___ | ___ | ___ |

***If you answered "yes" to any of the conditions above***, provide the following information for each condition:

| Type of Condition | Date of Diagnosis | Diagnosing Doctor |
|---|---|---|
| | | |
| | | |
| | | |

52. Have you taken any of the following medications over the last TEN (10) years:

| | | Yes | No | Don't Recall |
|---|---|---|---|---|
| a. | Insulin or glucose-lowering agents | ___ | ___ | ___ |
| b. | Narcotic pain relievers | ___ | ___ | ___ |
| c. | Analgesics | ___ | ___ | ___ |
| d. | Non-steroid anti-inflammatory agents | ___ | ___ | ___ |
| e. | Muscle relaxers | ___ | ___ | ___ |
| f. | Over-the-counter (non-prescribed) pain relievers | ___ | ___ | ___ |
| g. | Lipid-lowering agents (*e.g.*, statins) | ___ | ___ | ___ |
| h. | Disease-modifying agents (*e.g.*, monoclonal antibodies, such as Enbrel) | ___ | ___ | ___ |
| i. | Hypertension medications | ___ | ___ | ___ |
| j. | Insulin or other glucose lowering agents | ___ | ___ | ___ |
| k. | Steroids of any kind (including gluco-cortico steroids) | ___ | ___ | ___ |
| l. | Fungal medications (*e.g.*, methotrexate) | ___ | ___ | ___ |
| m. | Injectable products of any kind: Please specify: | ___ | ___ | ___ |

_____

53. Please list each time you remember being hospitalized in the TEN (10) years:

| Date | Name of Hospital | Reason for Hospitalization |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## IX. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

List the name and address of each of the following:

54. To the best of your ability, identify your current family and/or primary care physician and each of your primary care physicians for the last TEN (10) years:

| Name | Address | Approximate Treatment Dates |
|---|---|---|
| | | |
| | | |
| | | |

55. Each hospital, clinic, health care facility, or health care provider where you have received inpatient or outpatient treatment (including treatment in an emergency room) during the last TEN (10) years:

| Name | Address | Admission Dates | Reason for Admission |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

56. Each physician or health care provider from whom you have received treatment in the last TEN (10) years who is not otherwise identified in this Plaintiff Fact Sheet:

| Name | Address | Dates of Treatment |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

57. Each pharmacy that has dispensed medication to you in the last TEN (10) years:

| Name | Address |
|---|---|
| | |
| | |
| | |
| | |

## X. DOCUMENTS

Please produce any of the following documents and things that are currently in your possession, custody, or control, or in the possession, custody, or control of your lawyers. Please attach all non-privileged documents and things to your responses to this Fact Sheet.

1. All documents you or anyone acting your behalf reviewed in preparation of this Fact Sheet.
2. Records of physicians, hospitals, pharmacies, and other healthcare providers identified in response to this Fact Sheet.
3. To the extent not included in the foregoing, all records relating to any examination of the individual exposed to the NECC Product by a physician or other health care provider, conducted for any purpose during the past TEN (10) years.
4. If this Fact Sheet was completed by a Representative, instruments or other documents authorizing or empowering the Representative to act on behalf of the person claiming injury.
5. Death certificate, if applicable, as requested above.
6. If the individual exposed to the NECC Product has been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.

7. Copies of all documents from physicians, health care providers or others relating to the exposure to the NECC Product, or to any condition you claim is related to the exposure to the NECC Product.
8. All documents constituting, concerning or relating to product warnings or other materials provided to the individual exposed to the NECC Product or his or her agents, representatives or anyone acting on his or her behalf (other than those provided by your attorneys, or produced by the defendants in this case) in connection with the exposure to the NECC Product.
9. Any releases, covenants not to sue, or any other agreement(s) between you and any other person or entity relating in any way to the claims asserted in this lawsuit.
10. All press releases or other public statements made by or on behalf of you relating to this litigation.
11. All documents recording any communications concerning exposure to the NECC Product that you or anyone acting on your behalf had with any governmental body, regulatory agency, trade group, manufacturer or distributor, members of the press or news media, or other person.
12. All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation.
13. All documents relating to exposure or any alleged health risks or hazards related to exposure to the NECC Product in your possession at or before the time of the injury alleged in your Complaint (other than those produced by the defendants in this case).
14. All documents you or anyone acting on your behalf (and not your lawyer) obtained directly or indirectly from any defendant (other than those produced by the defendants in this case).
15. All photographs, drawings, journals, slides or videos relating to the injuries alleged in your Complaint.
16. If you are claiming lost wages or loss of earning capacity, any documents that refer, reflect, or relate to your past, present, or future earnings and earnings capacity, including but not limited to W-2s, 1099s, K-1s, tax returns, pay stubs, from the last 5 years.
17. All documents that record, reflect, or relate to any pecuniary loss or other damages, including all out of pocket expense documentation, that you claim resulted from the exposure NECC Product alleged in your Complaint.
18. Any diary entries, calendar entries, date book entries or other documents (including files maintained electronically) that reflect any alleged symptom, adverse reaction, or other injury resulting from the exposure to the NECC Product.
19. All documents referring or relating to any benefits, including, without limitation, Social Security disability benefits or any other disability benefits that you filed for, received, or were denied in connection with any injury or illness.
20. All documents in your possession, or in the possession of your attorneys, that you or your attorneys obtained directly or indirectly from the Defendants, other than documents produced by the Defendants in this litigation.
21. All documents in your possession, or in the possession of your attorneys, that you or your attorneys obtained directly or indirectly from any defendant in this case, other than documents produced in this litigation.

**VERIFICATION**

I declare under penalty of perjury that the information provided in this plaintiff's Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in this plaintiff's Fact Sheet, as required above.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respect incomplete or incorrect.

Signature:

_____

Print or Type Name:

_____